South Carolina Workers' Compensation Commission
1612 Marion St.
P.O. BOX 1715
Columbia, SC 29202-1715
(803) 737-5739
www.wcc.sc.gov

PRE-HEARING BRIEF
WCC File No:_____

Claimant's Name: _____ Employer's Name: _____

Address: _____ Address: _____

City: _____ State: _____ Zip: _____ City: _____ State: _____ Zip: _____

Home Phone: ( ) - Work Phone: ( ) - Carrier: _____

Preparer's Name: _____ Preparer's Phone #: ( ) -

A claim for workers' compensation benefits is made based on the following grounds:
☐ Injury ☐ Illness ☐ Repetitive Trauma

1. Compensation Rate: _____ 2. AWW: $_____ **Date of Injury:** _____
3. Type of injury and body part(s): _____
4. Facts in controversy: _____
5. Legal issues involved: _____
6. Unusual aspects: _____
7. Witnesses (designate if expert):* _____
8. Exhibits: _____
9. Medical evidence (indicate report pursuant to R.67-612; deposition or appearance):
10. Name, address, and specialty, if any, of the treating physician: _____
11. Impairment rating(s); body part(s); physician and date of opinion: _____
12. I am amending my Form 50/51 in the following manner: _____

I verify the contents of this form are accurate and true to the best of my knowledge.

Signature: _____ Email: _____

Date of hearing: _____ Time needed for hearing: _____

On behalf of ☐ Claimant ☐ Employer

File this form and proof of service on the opposing party according to R.67-611 and R.67-212. Do not send medical reports.
* Commissioners reserve the right to admit expert witnesses at hearings.